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# AHRQ Update

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## Strengthening the Health Services Research to Reduce Racial and Ethnic Disparities in Health care

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“Research on racial and ethnic disparities in healthcare has grown significantly over the past two decades, and continues to offer new insights into the causes of and possible solutions to care disparities. To strengthen this research, however, and to stimulate new insights and perspectives that may lead to innovative intervention strategies, the research enterprise may be strengthened in a number of ways.” – *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, 2002.

In a October 2002 *AHRQ Update*, we presented initiatives, including research, training, and data collection supported by the Agency for Healthcare Research and Quality (AHRQ), designed to help reduce racial and ethnic disparities in health care (Stryer, Weinick, and Clancy 2002). The article briefly mentioned a new policy on the inclusion of priority populations that AHRQ developed based on earlier policies on the inclusion of women and minorities. It also briefly described AHRQ’s new research office on priority populations.

The article discusses both the new inclusion policy and the Division of Priority Populations Research in greater detail. It also discusses other ways that AHRQ is “strengthening the research enterprise,” as recommended by the Institute of Medicine’s Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.

### OLD ISSUE WITH RENEWED ATTENTION

Although the issue of reducing racial and ethnic disparities in health care is old; four recent developments have sparked renewed attention.

In March 2002, the Institute of Medicine (IOM) issued a report titled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, and Nelson, 2002). The report was greeted with national news

headlines, and it continues to be cited in the media more than a year after it was released.

The report, derived from extensive reviews of the scientific literature on health care disparities associated with patient race and ethnicity, made some important recommendations. These included enhancing the equity and consistency of care through the use of evidence-based clinical practice guidelines, expanding the pool of minority health care providers and researchers, and implementing effective strategies and methods for conducting research that will help close the gaps in health care for minorities.

The second development is that the issue of ethnic and racial minorities also has gained a strong voice and advocate on Capitol Hill. In September 2002, Senate Majority Leader Bill Frist (R-TN) asked the General Accounting Office (GAO), the government watchdog agency, to prepare a report to evaluate the status of the Federal government's initiatives to reduce health disparities among Hispanics, African Americans, and other minority populations.

Sen. Frist also asked the GAO to assess the *Minority Health and Health Disparities Research and Education Act of 2000* (U.S. Public Law 106-525), which he coauthored with Senators Edward Kennedy (D-MA) and Jim Jeffords (I-VT). This legislation is the foundation of new legislation, titled *Closing the Health Care Gap Act of 2003*, which Frist introduced in May 2003. The GAO delivered the report, *Health Care: Approaches to Address Racial and Ethnic Disparities* (GAO Report No: GAO-03-862R), to Senator Frist in June 2003. It is available on the GAO Web site at [www.gao.gov](http://www.gao.gov).

The proposed legislation would expand AHRQ's research portfolio to identify and evaluate strategic strategies to assist clinicians in closing the gap between what is known and what is done in health care for minority populations and ensure that the findings of this research are translated into practice.

The third development is AHRQ's release of the *National Healthcare Disparities Report*, which was mandated in AHRQ's 1999 reauthorization legislation, along with its companion report, the *National Healthcare Quality Report*. The Disparities Report answers critical questions about differences in health care and provides a more complete picture of health care in America. In addition to patient race and ethnicity, the Disparities Report addresses

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income, education, geography and other characteristics associated with suboptimal care. Together, the reports provide a critical baseline that will help the Federal government, States, and the private sector identify and reduce avoidable disparities in health care.

Finally, the National Institutes of Health and AHRQ have both created new centers with explicit missions to support research to reduce ethnic and racial disparities in health care. As part of the *Minority Health and Health Disparities Research and Education Act of 2000*, Congress created the National Center on Minority Health and Health Disparities (NCMHD) within NIH. The mission of the Center, which builds on NIH's 10-year-old Office of Research on Minority Health, is to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. To that end, NCMHD conducts and supports basic, clinical, social, and behavioral research, promotes research infrastructure and training; fosters emerging programs, disseminate information; and reaches out to minority and other communities adversely affected by health disparities. NCMHD and AHRQ have co-funded important research initiatives, including the Excellence Centers To Eliminate Ethnic/Racial Disparities (EXCEED) program (Stryer, Weinick, and Clancy 2002).

## REDUCING DISPARITIES: A FOCUS IN AHRQ REAUTHORIZATION

AHRQ's 1999 reauthorization legislation directed the Agency to create a unit focused on priority populations which would ensure that specific priority populations are reflected in the research conducted and supported by this Agency (U.S. Public Law 106-129). The priority populations enumerated in the legislation are low-income groups; minority groups; women; children; elderly; and individuals with special health care needs, including individuals with disabilities and people who need chronic care or end-of-life health care.

On July 25, 2003, a notice in the *Federal Register* outlined a realignment of AHRQ's organizational structure, including the establishment of the Division of Priority Populations Research (DPPR) within the new Office of Extramural Research, Education and Priority Populations. The mission of DPPR is to coordinate, support, manage, and conduct health services research on priority populations.

The notice extensively outlines the nine charges laid out for the Division and describes how its functions will dovetail with the Agency's other research

centers and offices. Specifically, DPPR will be responsible for advising the Agency on matters relating to improving the quality, safety, and effectiveness of the health care of the legislatively mandated priority populations.

Other Division functions include developing research agendas on priority populations within the Agency's strategic planning process; serving as an expert resource for AHRQ staff, grantees, and stakeholders on issues relating to priority populations; assisting in the translation, dissemination, and application of Agency initiatives and programs designed to improve health care quality for its constituents; and developing new talent and creating an awareness of priority population research issues within the health services research community.

The Division works to coordinate its efforts with the efforts of foundations with related interests. In addition, a clear rationale underlying creation of the Division is to focus attention on the interactions between patient characteristics associated with an increased risk for suboptimal health and health care; for example, minority women and disabled children.

In essence, DPPR will drive AHRQ to emphasize research on priority populations as an essential part of the Agency's research mission and core activities. DPPR also will work to "strengthen the research enterprise" as recommended by the IOM, by helping the Agency think through some critical questions that will inform future research priorities.

## FRAMING RESEARCH QUESTIONS

The health services research community is at a critical juncture in its efforts to reduce racial and ethnic disparities in health care. We have amassed a superior body of evidence on disparities in health care: where they exist, who is affected, and what their consequences are. While it is important to continue to track trends in disparities, as the *National Healthcare Disparities Report* will do, the emphasis of research must shift to finding and testing ways to reduce disparities and improve the equity of the American health care system. Simply put, we must move beyond the "gee whiz" to "what can we do now."

This imperative raises some significant issues that must be addressed when articulating funding priorities. An important question is, "When should evidence be broad and when should it be specific to a population?" For example, we know from research on disparities that:

- African-American diabetics are seven times more likely to have amputations and develop kidney failure than white diabetics (Resnick, Valsania, and Phillips 1999).

- Elderly African-American stroke victims are less likely than whites to be alive 3 years after stroke (Bian, Oddone, and Samsa 2003).
- Girls who undergo surgery for congenital heart disease have 51 percent higher odds of dying in the hospital than boys do (Chang, Chen, Klitzner 2002).

In moving from the “gee whiz to the “what can we do now” to reduce the disparities cited in the examples above, we must learn when it is more effective to seek evidence for population-specific solutions and when it is most practical to focus specifically on quality improvement with a clear priority to support concentrated, customized outreach to the affected populations. Continued demographic changes and diversification of the U.S. population make this question an urgent priority for the nation.

As you have read in previous *AHRQ Updates*, an overarching priority for the Agency is to ensure that the findings of health services research are translated into improved practice and policy. Simply producing and publishing evidence is only a first step. For health services research to be effective in reducing health care disparities, it must be translated into useful and readily accessible strategies and tools that can achieve sustainable improvements in health care. For this translation to be effective, it must reflect and address the needs of the audience and the population experiencing health disparities.

Improving the safety, quality, and efficiency of health care for priority populations reflects both the strengths and limitations of health services research to date. With a few exceptions, the existing evidence base on disparities is a patchwork quilt of studies that are long on descriptions and short on solutions. As noted above, they reflect the “gee whiz.” In addition, studies in the existing body of evidence are scattered which makes it hard to help “tell a story” about racial and ethnic disparities that can be used as a lever for change.

AHRQ, with leadership from the Division of Priority Populations Research, has been working with the health services research community and the users of our research to set research priorities that respond to these critical issues. In addition, AHRQ formally released a new policy for the inclusion of priority populations in the research it supports.

## INCLUSION POLICY

AHRQ’s reauthorization legislation required the Agency to establish a process that would ensure that priority populations are included in its overall research portfolio. This new inclusion policy is effective as of October 1, 2003.

Currently, AHRQ grantees are required to follow guidance provided in a policy established by NIH in 1993 and amended in 2001, which governs the inclusion of women and minority subjects in research as appropriate to the science (*NIH Guide* 2001). AHRQ also encourages research to consider including children in their studies.

Under the new inclusion policy (*NIH Guide* 2003), researchers will be required to consider including one or more of the previously mentioned priority populations in their research project. They will be required to discuss the proposed plans to include priority populations in the application within the context of their scientific objectives and research methods. If an applicant elects not to include any priority populations in the study, he or she must explain why. The policy applies to all new and amended applications submitted to AHRQ: large and small research projects, training and career development grants, conferences, and investigator-initiated and solicited projects.

It is important to note that the new policy does not mean that researchers will be denied funding if they do not include a priority population. During peer review, applications will be assessed, including researchers' plans to include one or more priority populations or their justifications for not including them. Peer reviewers also will evaluate the researchers' proposals for outreach, recruitment, and retention of study participants, as well as methods for conducting subgroup analyses for priority populations, if applicable. These assessments will be factored in as part of the overall assigned merit score for each application.

The objective of the policy is to ensure that AHRQ's overall research portfolio is inclusive of these priority populations. In addition, tracking the results over time will be important in identifying critical gaps in knowledge and implementation.

For more information on the new inclusion policy, consult the *NIH Guide* at <http://grants1.nih.gov/grants/guide/notice-files/NOT-HS-03-010.html>. Answers to "Frequently Asked Questions" are available on the AHRQ Web site at <http://www.ahrq.gov/fund/ppopfaq.htm>.

## FINAL THOUGHTS

AHRQ's efforts to evaluate and strengthen our support for research that meets the needs of priority populations reflect the urgency to reduce and ultimately eliminate racial, ethnic, and socioeconomic disparities in health care. This will require a reframing of how the health services research community has

addressed these issues. We need to change our focus from documenting gaps in care to finding ways to close the gap. Moreover, our efforts to do so are likely to yield additional scientific insights.

The new inclusion policy lays out a vehicle for investigators to consider including priority populations in their research. AHRQ is committed to helping health services researchers enhance the disparities-related research they conduct.

The Division of Priority Populations is an excellent resource for the research community, and we always welcome your input on the issues and concerns facing the research community. Dr. Francis D. Chesley, M.D., Director of the Office of Extramural Research, Education and Priority Populations is available to answer questions concerning the work of the Division of Priority Populations. Contact Dr. Chesley at [fchesley@ahrq.gov](mailto:fchesley@ahrq.gov). Debbie Rothstein, Ph.D., who leads the implementation and evaluation of the Priority Population Inclusion Criteria, can be reached at [Drothste@ahrq.gov](mailto:Drothste@ahrq.gov).

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